HEALTH, WELFARE AND DEPRIVATION OF LIBERTY
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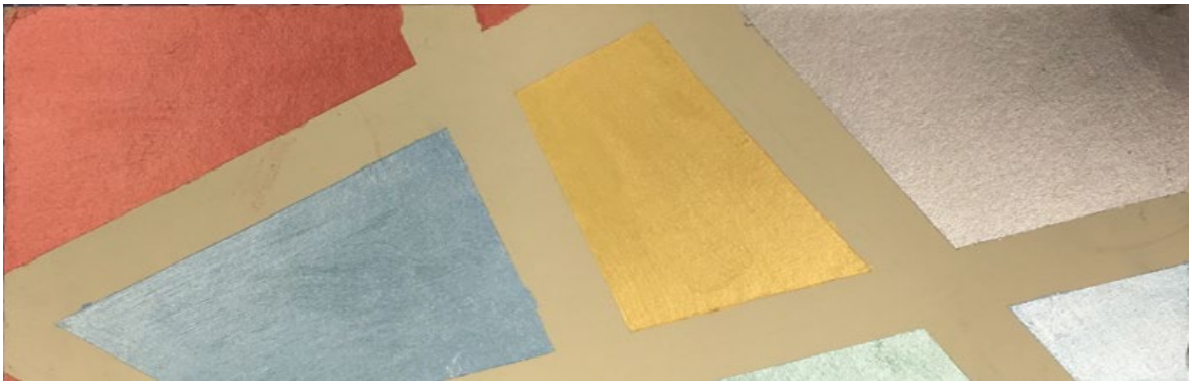

Welcome to the February 2025 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: myth-busting about DoLS and strong words about assessment of capacity of D/deaf people;

(2) In the Property and Affairs Report: revoking Deputyship for a person no longer present in England & Wales;

(3) In the Practice and Procedure Report: litigation capacity and a very clear statement of the ordering of the capacity test, delays in obstetric cases and guidance on neurodiversity before the courts;

(4) In the Mental Health Matters Report: the Mental Health Bill progresses and two important Upper Tribunal cases;

(5) In the (new) Children's Capacity Report: deprivation of liberty before the courts and Parliament, when capacitous consent is not enough, and best interests and the clinical circling of the wagons;

(6) In the Wider Context Report: The Terminally Ill Adults (End of Life) Bill and capacity, CCTV and care homes, and using the arts to be more creative in capacity assessment.

(7) In the Scotland Report: Scottish Government's law reform proposals – the consultation responses, and the OPG digitalises.

There is one plug this month, for a free digital trial of the newly relaunched Court of Protection Law Reports (now published by Butterworths. For a walkthrough of one of the reports, see here.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

"On a DoLS" – mythbusting by a (rightly) exasperated Court of Protection

Re EM (Deprivation of Liberty, Care Planning & Costs) [2024] EWCOP 76 (T2) (HHJ Burrows)

Article 5 ECHR – DoLS authorisations

Summary

In this case, HHJ Burrows helpfully busted some disturbingly frequent myths about DoLS. The case concerned a young woman, personalised by the court with the name "Emma," and for present purposes, the central passages of wider relevance are these:

> *45. Having read the documents in this case, including those concerned with Emma's own wishes and feelings, it seems to me the Court needs to be very clear in the language it uses.*
>
> *46. The acronym DOL (or DoL) or its plural "DoLs" comes from the wording of Article 5 of the European Convention and refers simply to "deprivation of liberty". The term "DOLS" refers to Schedule A1 of the MCA, otherwise known as the Deprivation of Liberty Safeguards. Emma is therefore subject to an order that authorises her deprivation of liberty, which could be called a DoL or DoLs order. She is not on a DOLS.*
>
> *47. I hope not to confuse things further by explaining my understanding of the law. The MCA requires decision makers to make decisions for people who cannot make those decisions for themselves, where necessary (see ss 1-4 MCA). That includes issues over residence and care. It enables decision makers to decide on care plans that meet the best interests of the person concerned. That is the starting point. A care plan in P's best interests, and the one which adopts the least restrictive option is what the decision maker must choose. If that plan involves or may involve a deprivation of P's liberty, then it needs to be authorised and will be if it is necessary and proportionate in furthering P's best interests.*
>
> *48. It can be authorised under Schedule A1 of the MCA if the person is 18 or older and is detained in a care home or hospital. These are the DOLS. If the person is not yet 18 or is somewhere other than a hospital or care home, the Court must decide whether to authorise the care plan under ss 15 and 16 MCA.*
>
> *49. The inherent jurisdiction has been used in Emma's case to authorise her deprivation of liberty outside a statutory regime. These are also known as DoL or DoLs orders, with good reason.*
>
> *50. Such authorisation, by any of these avenues, is permissive rather than mandatory. Or put another way, it enables the carer to use restrictions that*

amount to a deprivation of liberty, it does not require them to do so.

51. Therefore, the expression "on a dol" or "under a dol", whilst perfectly legitimate abbreviations, must be understood properly and within that context. To be "on" or "under a dol" means to be subject to an order (or authorisation) approving and authorising a care plan which allows the carer to use restrictions that amount to a deprivation of liberty in the best interests of P. Clearly, the emphasis here is on the care plan itself and not the legal status of the restrictions that can be used. The care plan to be used is still a decision to be made by the carer/clinician/MDT in charge on the basis of what they consider to be needed in the circumstances that arise, and what is in P's best interests.

52. Unfortunately, when the Court authorises such a care plan that amounts to a "dol" it is seen as being mandatory, like the Court has imposed a prison sentence. That gives rise to an unfortunate misconception on the part of the people who are the subject of these orders that the order, while it remains in place, requires those providing care to keep them actually locked in and locked up.

53. In some extreme cases coming before the National DOLs List and the Court of Protection it is easy to see why the misconception arises, particularly when the options for care are all inadequate, P's behaviour is extreme, and LAs are fighting a very difficult and seemingly endless battle to keep P safe.

54. However, the principle is always the same. The Court will ask questions like: what is the care plan and how has it been arrived at? What are the risk assessments of alternative plans compared with this one? What does P think? What do other relevant people under s. 4 MCA think? Does the LA/NHS provider (as the case may be) consider the care plan to be the least restrictive option that will address P's needs? What steps are being taken to reduce the need for such an intense care plan? The Court is obliged to scrutinise the answers given.

55. It is important to emphasise though that the care plan is King here. That is how Emma's case should be seen. Considering Dr Khan's engagement with Emma, an attempt is being made to give effect to what Emma wants in her care plan. She wants less restriction. If the clinicians, social workers, and other relevant professionals can work with Emma (and perhaps her family) to devise a care plan that does not amount to a deprivation of her liberty, and that care plan is in her best interests, then the Court will authorise it.

What particularly troubled HHJ Burrows was that:

56. The LA in this case is (I think) planning to move Emma to a place where there will be no need for "a dols". However, through their counsel it was made clear to me that could only happen if I "lifted the dols". This is incorrect. If the LA devises a care plan whereby Emma can move to another place where she will not be deprived of her liberty, there will be no need for the Court to authorise her deprivation of liberty. If a plan is devised at her present placement that does not amount to a deprivation of Emma's liberty, the Court will not need to authorise one.

57. So profound has the language and the law been confused in this area, that these two statements of what should be the blindingly obvious, appear necessary.

58. It is important to remember that the Court is in place to ensure that disputes about capacity, best interests and the proportionality of restrictions are resolved as well as ensuring that there is a consistent scrutiny of a care plan that imposes significant restrictions on P.

59. Once again, however, care planning and the assessments and consultations around that are what is most important. That means Emma is central to the process. By focusing on the Court and the making and un-making of a "dol", Emma and other people in her position are made to feel peripheral to the whole process. Many of them conclude that "getting off the dol" is essential before they can be part of the process. Many feel that when on a "dol" they are filed away and forgotten only to be taken out for scrutiny when someone else makes a fuss.

60. In fact, the whole MCA/Court of Protection process, particularly when concerned with Article 5 rights, is about ensuring that these care planning decisions are constantly reevaluated to ensure that P's best interests are served through the least restrictive option, and P is central to the whole process.

61. At the October hearing, I therefore approved the care plan I was invited to approve at the placement. That care plan amounts to a deprivation of Emma's liberty not because the Court says it does, but because the restrictions imposed under the care plan are said to be necessary, proportionate and in her best interests according to those involved in her care, and they place Emma under continuous supervision and control and she is not free to leave the placement.

62. The Court approves the restrictions, it does not create them.

Separately, HHJ Burrows was exercised by the "serial breaches" by the local authority of directions made in advance of the relevant hearing, and came to the conclusion that the threshold for the making of a costs order had been met:

> *72.* […] *because of the wholesale breaches of the order made to ensure the hearing in September was not wasted. As a result, it was wasted. That non-compliance took place within the context of the earlier complaints made by the OS in July. The October hearing went someway towards ensuring the case was back on track, but that simply emphasises the waste the September hearing was. For those reasons I am satisfied that I should depart from the general rule and make an order for costs against the LA.*

Comment

HHJ Burrows' observations about what DoLS (and orders made by the courts here) actually mean, as opposed to what they are understood to mean, are trenchant. That they were required is, frankly, more than a little depressing.

D/deaf individuals and capacity assessment – a salutary tale

Oldham MBC v KZ (Fluctuating Capacity: Anticipatory Declaration) [2024] EWCOP 72 (T3) (Theis J)

Mental capacity – assessing capacity

Summary

This case is a salutary tale in which a failure to provide a Deaf young man with a suitably equipped translator and/or assessor very nearly had the effect of writing off the abilities he had and seriously underestimating his capacity to make decisions for himself. The Vice President,

Theis J, also had to grapple with the role of anticipatory declarations and when they might be permitted under the MCA.

KZ was 20 years old at the time of judgment but had been the subject of proceedings since his late teens. One of five children who appeared to have lived between Pakistan and Spain before moving to the UK, KZ was described as deaf, with a cochlear implant but resistant to its use: he is recorded as preferring to communicate in British Sign Language (BSL), notwithstanding that his parents, with whom he lived for the first half of his life, did not sign at all.

Theis J's judgment describes a number of years of a problematic home life: KZ living in hotel rooms with his father, excluded from placements, exhibiting sexualised behaviours, arrested on stalking offences and considered a potential risk to others. From 2021 onwards KZ is recorded as attending a specialist school with 2:1 carers, some of whom are noted to be BSL trained.

In 2021, applications for deprivation of liberty authorisations were made and capacity assessments were first carried out. KZ was assessed by Dr Lisa Rippon as lacking capacity in all relevant areas – residence, care, contact, engaging in sexual relations and receiving a covid vaccination. In a move a later assessor described as "*frankly astonishing*" (paragraph 95), Dr Rippon was assisted in producing her report by the BSL Level 1 qualified service manager at KZ's placement acting as translator. BSL level 1 effectively means understanding a limited range of simple words and sentences enabling the user to give and follow simple directions or instructions or provide simple familiar statements or descriptions. It does not obviously equip an individual to provide translation support for an assessment of mental capacity across a broad spectrum of decision-making.

Nonetheless, the Dr Rippon carried out the assessment on KZ and concluded as a result that he was suffering from a "*borderline learning disability*" as well as some autistic features (paragraph 47).

As a result of Dr Rippon's conclusions (and it should be noted that the judgment does not include any criticism of Dr Rippon personally), according to Theis J, proceedings "*nearly concluded in January 2024 on the basis of expert evidence regarding KZ's capacity that stated he lacked capacity in all relevant areas, including residence, care and support and contact*" (paragraph 2).

Following a move to a new placement, concerns were raised regarding the capacity assessment, regarding both the conclusions reached and the manner in which the assessment had been carried out. A further assessment was ordered. This assessment was carried out by a Clinical Psychologist with specific expertise in assessing deaf people, Dr O'Rourke, acting with the support of a Registered Sign Language Interpreter.

Dr O'Rourke's conclusions were markedly different from her predecessor's. She concluded that KZ was "*very far from the diagnosis of a learning disability*" (paragraph 50(1). Rather, she diagnosed KZ as suffering from *"extreme language deprivation"* which, albeit that it did compromise his ability in a number of domains, left undisturbed his capacity to make decisions about his residence and his contact with his parents.

The Vice President gave the following guidance for the assessment of capacity in deaf in future cases.

> *96. As regards wider issues concerning the assessment of mental capacity of Deaf individuals the following should be an essential part of any such assessment. The experience in this case*

demonstrates the use of a non-specialist expert is not an appropriate substitute for the specialist assessment and risks incorrect conclusions regarding capacity being reached. Where an assessment is required the following considerations should guide any assessment of a deaf individual fluent in BSL:

> *(1) Any mental capacity assessment of a deaf individual fluent in BSL should ideally be undertaken by an assessor who is suitably qualified to communicate at the relevant level of BSL. If that is not done, there should be a clear explanation why and what measures, if any, are proposed to be in place to manage that gap.*
>
> *(2) The assessor should ideally have a background in understanding deafness and engaging with the deaf community. If they don't, there should be a clear explanation why they are undertaking the assessment without such knowledge.*

97. These essential steps should prevent the difficulties encountered in this case occurring again. They accord with the wider provisions regarding expert evidence in Part 15 Court of Protection Rules 2017 which make clear 'it is the duty of an expert to help the court on matters ***within his own expertise'*** *(emphasis added) (PD15A paragraph 2). There is an obligation on those proposing an expert instruction, and on the expert themselves, to make sure that expert has the requisite expertise to prepare the expert report being sought.*

Alongside this, the court was tasked with grappling with the issue of when and whether to make anticipatory decisions in the case of an individual, like KZ, who was determined to have decision-making capacity in a number of domains, but to lose it at times of "dysregulation".

Noting the two competing routes to a finding of "longitudinal capacity" by Lieven J in *A Local Authority v PG (by her litigation friend, the Official Solicitor) and an NHS Integrated Care Board* [2023] EWCOP 9 – the longitudinal view taken by Sir Mark Hedley in *Cheshire West v PWK* [2019] EWCOP 57, versus the "anticipatory" approach adopted by Cobb J (as he then was) in *Wakefield Borough Council v DN* [2019] EWHC 2306 (Fam) – Theis J concluded:

1. KZ regularly became dysregulated;
2. He was cared for by a consistent team who would therefore be able to assess whether he had lost capacity in any relevant domain (at paragraph 87).
3. The anticipatory declarations proposed by the local authority were workable according to the care plan they proposed;

The s.16(1) apparent exclusion – ie that it only enables the court to make orders *"if a person lacks capacity"* identified by Hayden J in *GSTT v SLAM and R* [2020] EWCOP 4 – was not applicable in circumstances where *"this is not a case where there is a risk that KZ will lose capacity, it is a case where he does lose capacity, albeit it fluctuates*" (paragraph 72).

In those circumstances, Theis J accepted the local authority submission that *"the least interventionist approach to capacity that promotes KZ's autonomy and capacity would be achieved by making an anticipatory declaration as compared to the longitudinal one*" (paragraph 72).

Comment

The trenchant observations in paragraph 97 about the approach capacity assessment of

D/deaf people relate to proceedings before the Court of Protection; the observations in paragraph 96 apply across the board.

In relation to the other feature of the case, the Lieven J approach to "longitudinal" assessment has become increasingly popular in cases where local authorities are confronted with high-functioning yet difficult to manage service users. Many practitioners will have found this worrying, given the "off-switch" that it effectively applies to the capacity of individuals who fall prey to heightened emotions and the infamous "dysregulated" behaviour. Theis J's observations regarding the *"least interventionist approach"* that anticipatory declarations provide carry a great deal of attraction – albeit that this kind of approach relies heavily on a highly skilled, consistent care team which, sadly, many individuals do not currently have the good fortune to be cared for by.

It is also not entirely clear whether the anticipatory 'declarations'[1] she made were made on the basis of s.16(1) or s.15, but we suggest that the proposition put to her by the local authority and accepted blurred two conceptually distinct situations:

(1) Where a person, in fact, lacks capacity when their decision-making is assessed across the material time (the *PG* situation). At that point, s.16(1) is in play because the person lacks capacity for purposes of the exercise of the Court's jurisdiction.

(2) Where a person has capacity, but loses it under particular circumstances. At that point, if the person has capacity at the point that they are before the court, s.16(1) simply cannot apply, and the court is reliant upon s.15(1)(c) to make anticipatory declarations as to lawfulness and /or the inherent jurisdiction of the High Court insofar as it is being asked to make any declarations relating to deprivation of liberty.

Sexual capacity and contact

JC v Cornwall Council and ors [2024] EWCOP 75 (T2) (HHJ Cronin)

Mental capacity – sexual relations

Summary

This is another judgment, determined in the autumn of 2024, but only appearing on Bailii more recently, on the question of capacity to engage in sexual relations. JC was a 58 year old with a mild learning disability, who had been found (by agreement) to lack capacity to make decisions about where to live, what care and support to receive, contact with others, use of social media and the internet, and management of their property and affairs. HHJ Cronin noted that there were various considerations that people generally might take into account when deciding whether to engage in sexual relations that are not part of the relevant information identified by the Supreme Court in Re JB – "*that engaging in sexual relations may result in emotional distress or disappointment* […] *and that engaging in sexual relations may result in a negative reputation for promiscuity*".

The issue in JC's case was whether JC (who used the pronouns 'they' and 'them') was able to understand the need to obtain consent before and throughout sexual activity, and to use or weigh that information, as a result of JC's difficulty in recognising subtle signals and body language. JC had a history of predatory sexual behaviour towards children and adults and had asked friends for sex when they had already

[1] The word used at paragraph 88.

indicated they were not interested, as well as failing to understand that a friend agreeing to stay overnight was not also thereby agreeing to have sex. An independent expert had carried out the capacity assessment, despite JC only engaging in the assessment in a limited manner, ultimately concluding that JC would not be able to recognise the non-verbal withdrawal of consent during sex, due to autism-like trait. HHJ Cronin accepted that *"non-verbal signals as to consent or refusal or withdrawal of consent are important parts of the relevant information needed to decide to engage in sexual relations. These will include eye contact, averting the eyes, making hand or arm gestures, folding arms, turning away, moving closer, making a face, touching the other person or pushing them away: these are all commonplace in the circumstances of one person approaching another seeking to have sexual relations or in the response of the person approached, both preceding, and during intimacy, and possibly more commonplace than verbal communication."* HHJ Cronin held that as a result of autistic-like traits and learning disability, JC was unable to understand non-verbal signals, or *"recognising meanings alternative to assumptions made or inferred from other actions (such as agreeing to stay overnight), or meanings inconsistent with JC's own wishes, in behaviours such as K agreeing to stay overnight in JC's property. Since JC cannot understand that information when it is in non-verbal form, they lack capacity to decide to engage in sexual relations."*

Comment

The thorny issue of capacity to engage in sexual relations continues to trouble the courts, particularly in the context of people who display harmful sexual behaviour and pose risks to others. This judgment, decided before the Court of Appeal's decision in *ZX* (the subject of this webinar by Tor and Francesca Gardner), does not contain any explanation as to how the Official Solicitor contended that it was consistent with accepting JC lacked capacity in respect of contact to argue that JC lacked capacity in respect of sexual relations. An inability to understand other people's motivations and behaviour other than by direct verbal information appears likely to lead to the same result in both areas of decision-making. There were in this case very clear examples of JC failing to understand such non-verbal information and reaching the wrong conclusion about consent as a result. It will be important to consider such evidence in similar cases, to avoid leaping too quickly from a diagnosis of autism or autism-related traits to an inevitable conclusion that P lacks capacity to make decisions about interactions with other people.

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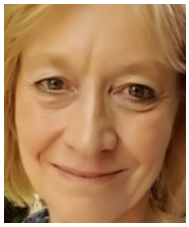

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in March. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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